



August, 1984

***Survey of community based
communication programs for
persons with developmental handicaps***

Prepared for the Ontario
Ministry of Community and Social Services
by Carolyn Sherk Consultants



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Dear Readers:

We are pleased to present to you this survey of community based communication programs for persons with developmental handicaps in Ontario funded by the Ministry of Community and Social Services. The report provides a descriptive overview of these relatively new programs.

Most of the communication programs described in the survey are less than 10 years old. They are part of a range of community support services that were developed by community agencies after the introduction of the Developmental Services Act in 1974. Included in this range are such programs as infant development, behaviour training, family support, and others.

This is one in a series of reports that document the experiences of service providers in the delivery of community support programs. As with similar reports on family support, infant development and behaviour training programs, this survey is a means of sharing, with the service community, information that can contribute to learning from each other's experiences, to self evaluation, and to improving the quality of services provided.

We think that this particular survey of communication programs will be of interest to a wide range of service providers that use a mediator model of service, that is, an approach where the program staff provides instructions and training to parents and other care or support providers who then work directly with the client.

Yours very truly,

A handwritten signature in dark ink, appearing to read "John Burkus".

John Burkus

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1. INTRODUCTION

History

Over the past decade, the Ontario Ministry of Community and Social Services has been funding programs to assist developmentally handicapped persons in the province develop their communication skills. Trained speech pathologists and other communication counsellors were employed to provide services to the developmentally handicapped. Initially, the services were provided predominantly to residents of the Schedule I (Ministry operated) and Schedule II (Ministry funded) facilities. However, in 1976 the Ministry began implementing a strategy of providing services in non-residential settings as well. Communication programs were included in the range of support services to be provided in the community.

Community-based communication programs were introduced in the province on a project basis. Any non-profit incorporated body could apply to the Ministry for funding of a communication program. It was required that an adequate number of clients who needed a communication program be identified. Proposals were reviewed by local advisory bodies (M.R. Working Groups) in light of a Community Needs Analysis and District Plan. Legislative authority for the projects was provided under the Developmental Services Act. Guidelines issued by the Ministry set out the purpose, definition, objectives, curriculum content, program components, staffing structure, facility requirements and program evaluation requirements.¹

By 1983, there were fifteen community-based communication programs in the province. About 45 staff served approximately 1,300 clients at a cost to the Ministry of about one million dollars annually.

¹ The Ministry's Communication Guidelines are attached in Appendix A.

1.2 Reason for this Review

The Ministry introduced community-based communication services on a project basis initially so that subsequent full scale implementation would be based upon accumulated experience. However, most of the original projects became ongoing operations without a prior review of which aspects of the programs should be maintained, modified or discontinued.

In 1983, the Ministry's Policy Development Branch undertook a plan to review three community support services programs, including communication programs. The programs included in the review are funded under the Developmental Services Act and are community based rather than those based in residential facilities.

The purpose of the review was to :

- provide a profile and analysis of community-based programs for developmentally handicapped persons, and
- identify policy and program issues that should be addressed by the Ministry

This report presents the profile and analysis of the communication programs as they operate in the province now. Profiles of three other community support programs for persons with developmental handicaps including the family support worker, infant development and behavior training programs were completed and sent to interested groups during the past two years. A review and consolidation of policy and program issues related to communication and these other community support programs is currently in progress.

1.3 Methodology

The approach for this review was to encourage maximum involvement from the service providers without intruding into the day to day operation of their programs.

Staff from the Ministry's Area Offices supplied a list of the communication programs and the names of appropriate program staff in each area. A total of 15 programs were identified.

All agencies funded by the Ministry for communication programs and various program supervisors involved with the programs were invited to a day-long workshop in Toronto on September 28, 1983. 24 people attended. The workshop provided the participants an opportunity to share information about the services as they now exist and their ideas about future directions for the programs.

Following the workshop, a detailed questionnaire was prepared. Each program was asked to provide statistical information and staff opinions on the topics listed below. Fourteen programs responded to the written questionnaire.² Follow-up visits or telephone calls were made to each of the respondents to discuss the program's experiences and concerns in more depth.

Because of the wide variety within the communication programs, different aspects of the programs are examined in some detail. Group discussions at the workshop, written answers to the questionnaire and subsequent personal discussions with individuals in the programs provided a large body of information about the programs.

This report of the detailed findings divides this information according to the headings in the questionnaire. In this way, individual program staff can compare their responses to the questionnaire with the experience reported by programs elsewhere in the province.

Separate chapters of this report will deal with each of the following headings:

- Organizational Auspices
- Program Mandate
- Admission/Discharge Procedures
- Service Delivery Practices and Client Characteristics
- Resources: Staffing and Budgeting
- Program Evaluation
- Reporting Requirements
- Community Relationships

² Appendix B lists the Names, Agencies and Addresses of the respondents. The questionnaire is included as Appendix C.

2. ORGANIZATIONAL AUSPICES

According to the guidelines issued by the Ministry in 1977, any non-profit incorporated body was able to apply for funding of a communication program.

In some areas, groups wishing to establish a communication program for developmentally handicapped have preferred to use 'generic' agencies as sponsors. The term 'generic' refers to agencies, usually hospitals or public health departments, that serve the general public. The university sponsored program is also operating under the auspices of a generic agency.

Local Associations for the Mentally Retarded have also applied to the Ministry to fund a communication program as an additional component of the organization's services to the developmentally handicapped. Two programs are based in non-residential facilities (Surrey Place Centre in Toronto is operated by the Ministry and the Algoma District Mental Retardation Services, is operated by a community board). These programs provide a range of services specifically for developmentally handicapped persons in the community. For the purposes of this review, the association and facility sponsored programs are considered similar in terms of their clientele, range of programs and focus of service.

Independent, usually parent-sponsored agencies, have also been established specifically to provide communication and sometimes other related support programs for developmentally handicapped children in the community.

Of the 14 programs included in this review:

- 6 are sponsored by hospitals or hospital affiliated agencies
(5 by hospitals and 1 by a university affiliated with a hospital)
- 3 are sponsored by Associations for the Mentally Retarded;
- 2 are sponsored by non-residential facilities; and
- 3 are new agencies created by independent boards specifically to provide communication and related community support services.

Most of the communication programs themselves are new. Although communication services have been provided by the 2 non-residential facilities since the early 1970's, the other 12 programs all began providing communication services after 1976, half of these programs were established since 1980.

Sponsorship has changed for only two of the programs. Both have changed from operating under the auspices of a 'generic' agency to become an independent organization.

2.1 Advantages of Sponsorship by Particular Types of Organization

When asked about the advantages of being sponsored by the particular type of organization, the program staff expressed the following opinions:

Advantages of Sponsorship by Hospitals and Hospital Affiliated Agencies

Professionals employed within hospitals preferred to be involved with a program that served both developmentally handicapped persons and the general population. This variety within the clinic setting gives them the opportunity to exchange program and case specific problems and ideas with other speech pathologists.

It was reported that programs operating within hospital settings are identified with a well known and highly regarded community facility. The status associated with hospital affiliation was particularly advantageous in arranging time for appointments for adult clients in the workplace setting. The central location of the hospital in the community was also considered advantageous.

It was reported that the hospital setting encourages co-ordination of services between the hospital's speech pathology program for other clients and its communication program for developmentally handicapped clients. The hospital setting also provides easy access to the clients' physicians and to other professionals (physiotherapists, occupational therapists, psychologists, and audiologists).

In addition, the opportunities for research were reported to be enhanced in a hospital setting because of the accessibility to educational programs and medical library facilities.

The linkage with other professionals is considered beneficial for programs as well as personal professional development. Membership in Speech/language or rehabilitation departments includes an emphasis on continued professional education and input from other professionals.

From a management structure point of view, supervision and accountability through the organization were valued. Administrative, financial, and space resources were mentioned as advantages to programs sponsored by larger, hospital organizations.

Advantages of Sponsorship by Associations for the Mentally Retarded and Non Residential Facilities

Four of the five programs sponsored by Associations for the Mentally Retarded and non residential facilities for developmentally handicapped persons in the community (3 Associations and 2 facilities) commented on the advantages of operating communication programs under these auspices.

It was reported that these programs were able to serve clients of greatest need, the developmentally handicapped, who are often a low priority within other programs that are not targeted for this population.

The non residential facilities are able to focus on long-term interdisciplinary management rather than on limited services such as diagnostic assessment with short term/ interim rehabilitation services.

The communication programs sponsored by the non residential facilities and the Associations for the Mentally Retarded are part of a network of services specifically established to serve the multiple needs of developmentally handicapped clients. This often gives the speech pathologists immediate access to a child's case file, to parents, teachers and other resource consultants and to schools and residences.

Several respondents considered it important that the communication program be able to serve a broad age range. Unlike school settings, these agencies serve individuals from the age of two to sixty-five.

Advantages of Sponsorship by Independent Agencies

Respondents from programs sponsored by independent agencies that focus on communication and related community support services, valued the advice and direction of board members in the development of these programs.

The board of directors of one program has considerable experience and interest in the specific approach to providing communication programs to developmentally handicapped children. The board's support and direction encouraged the staff to develop and critique these new approaches.

Because these agencies provide only communication and related programs to developmentally handicapped children in the community, the staff found that the focus of effort on specific services for a specific population provides an environment for continually improving the efficiency and quality of delivery of the communication services.

Advantages of Sponsorship by Parent/Family Boards

This category of sponsorship by parent or family boards includes some agencies from the preceding two categories. Parental involvement on boards was reported as beneficial in maintaining the program's emphasis on family needs and ensuring that service delivery stays flexible to adapt to specific situations.

2.2 Disadvantages of Sponsorship By Type of Organization

The respondents to the questionnaire were also asked their opinions on the disadvantages to the program of being sponsored by the particular type of organization.

Disadvantages of Sponsorship by Hospital or Hospital Affiliated Agencies

Four of the six generically sponsored programs mentioned disadvantages of this type of sponsorship.

Since in some programs only a few of the team members working with the program's clients are situated within the agency, they found it difficult to implement a team approach with staff from other community agencies who were involved with the clients.

One reported disadvantage of hospital sponsorship was that other professionals often associate these programs with a medical model approach to remediation of communication disorders.

There was concern that poorly defined roles of various professionals within and outside the hospital or hospital affiliated setting could sometimes lead to overlap of services.

One program expressed the concern that under the hospital sponsorship the program was not independently recognized by the Ministry and was unable to control finances.

Although not expressed as a disadvantage, one respondent noted the changing focus of the overall hospital system toward more community involvement. As this was a new focus, it was suggested that more linkages were needed among health agencies as new programs are established.

Disadvantages of Sponsorship by Associations for the Mentally Retarded and Non Residential Facilities

A number of disadvantages were mentioned consistently by respondents from programs sponsored by agencies serving only developmentally handicapped persons:

The three association sponsored programs limit service to those enrolled in the agencies' other programs such as day nurseries, group homes or workshops. This restriction excludes individuals who could benefit from a communication program but are not enrolled in one of the other agency programs. In addition, parents of children who could benefit from the programs offered by these sponsors are often reluctant to use a service that "labels" the child.

Program staff also reported that other agencies serving a broader range of clients tend not to accept referrals from the programs that serve the developmentally handicapped persons. This situation is counter to the approach of encouraging normalization of the developmentally handicapped and the philosophy of integrating these individuals into the community.

A widely reported disadvantage is the program staff's sense of isolation from other speech and language professionals in particular and sometimes from other professionals. In one program, the staff of the communication program is the only professional offering direct service or consultative support service within the organization.

Disadvantages of Sponsorship by Independent Agencies

Few disadvantages were reported regarding independent sponsorship. The most well established program in this category focusses on communication programs for children in a limited geographical area. It mentioned problems with limited funding to meet parental expectations. One newly formed agency found no disadvantages with its sponsorship. Another program, that offers services to children in a large geographic area, finds it difficult to merge the differences of geography, funding agencies and models of client management within its overall program.

Disadvantages of Sponsorship by Parent/Family Boards

Disadvantages were reported where boards are dominated by parent volunteers rather than being balanced by a variety of perspectives, training and experiences. Where a board is dominated by parent volunteers, some of the respondents reported little understanding by the board and agency of the nature and scope of the services that can be provided by a communications program. In some agencies the only programming encouraged is direct therapy whereas the Ministry guidelines recommend a mediation model. Limited or no opportunities are provided to engage in research and professional development.

It was reported that a good balance among parent/family, consumer and professional input was difficult to achieve with parent dominated boards. Decisions regarding models of service, appropriate staff qualifications and other service issues may be based upon inadequate knowledge and information about communication programs.

Summary

In summary, the communication programs in the province are sponsored by a variety of organizational groups. The speech pathologists in programs sponsored by hospitals report general satisfaction with this sponsorship although developing co-operation with other agencies in the community has been difficult for some. Programs operated under the auspices of Associations for the Mentally Retarded find it important to provide services to developmentally handicapped and are concerned that without the sponsorship of the associations, these individuals might not receive service. Programs that are associated with organizations that have the capacity to provide long term multidisciplinary services are able to effectively coordinate a continuum of services for clients with multiple needs. Disadvantages were reported in working under the auspices of volunteer organizations that limit their services to the developmentally handicapped and have little experience with employing professional support staff.

3. PROGRAM MANDATE

This section of the paper reports on the goals and objectives of communication programs as suggested in the Ministry's guidelines, the objectives and mandate of the various programs currently operating and the extent to which the programs receive requests to provide services which are outside their mandate.

3.1 Goals and Objectives in the Ministry's 1977 Communication Guidelines

According to the Ministry's 1977 guidelines, communication intervention programs are designed to assist any developmentally handicapped person, aged two and over who is communicatively impaired, to attain developmental potential. The guidelines suggested that all communication programs should be designed to:

- a) assess and evaluate eyesight, hearing, receptive and expressive communication;
- b) assess and evaluate the client's natural communication environments and the nature of the client-mediator interaction;
- c) facilitate the development of communication skills through programming;
- d) provide mediator training;
- e) provide mediator education;
- f) provide liaison with other community resources by referral and/or consultation.

The guidelines also indicated that programs may receive funding to meet some or all of the following objectives:

- g) remediate physical impairments affecting sight and/or hearing through adaptive equipment where financially feasible;
- h) develop novel assessment, treatment and training methods and materials;
- i) develop new evaluation tools;
- j) provide training to community agents;
- k) provide public education; and
- l) provide practical training.

3.2 Objectives and Mandates of Individual Programs

During the workshop discussions and in later interviews, it became apparent that some of the communication programs were unaware of the Ministry guidelines. Other agencies had used them extensively as the basis for establishing their programs.

As a group, the communication programs ascribe to the objectives stated in the guidelines.

All of the programs are involved in assessment and evaluation of the client's communication skills, and in development of programs to maximize the communication skills of clients.

Most include within their mandates a statement regarding the program's role in providing emotional support, advice and information to parents and other caregivers.

Co-ordination of services with other agencies in the community is a feature of all programs.

A number of programs mentioned the responsibility of the program to stimulate public and professional awareness and understanding of communication disorders.

However, beyond these general objectives, the mandate of individual programs differ in their focus on specific elements. These variations are in four areas: the age of clients, the use of the mediator model, research and training, and the development of new programs.

Age of clients:

One program's mandate limits service to adults, 5 programs are designed to serve children only and the other 8 programs will serve all age groups, although preference is often given to children.

Use of the Mediator Model:

Objectives regarding the provision of mediator training and education are explicitly included by eight programs in their statement of objectives. The other programs mentioned their role in counselling, demonstrating techniques and the use of the mediator approach, when appropriate.

Research and Teaching:

Five programs made particular reference to the development of new methods of service delivery and the teaching of professionals as part of their mandate.

Specific research and training objectives included:

- to evaluate the effectiveness of the training model and to modify the model as a result of any new research findings;
- to act as a service model for other professionals and agencies who are responsible for servicing language-delayed children;
- to design and utilize standards for determining program success;
- to provide teaching concerned with communication disorders of developmentally handicapped for other professionals, university students and volunteers involved with this population;
- to conduct research in the area of communication disorders and language development; and
- to adapt or create materials to facilitate non-oral communication where oral communication is unrealistic because of a physical disorder.

Development of New Programs:

Three programs mentioned program development and outreach as specific objectives. Two of these referred to geographic areas where there are few services available. Another mentioned in its mandate efforts to develop a generic or multi-service capacity in the community for the delivery of services in order that more children can be identified who have developmental lags without necessary labelling the child mentally retarded.

3.3 Requests for Services Beyond the Program's Mandate

When asked if the programs are requested to provide services which are not considered part of the program's mandate, nine of the respondents reported that they had no such requests.

The five programs that did receive such requests all mentioned services requested by the school system. The programs are often asked to provide speech/communication assessments and therapy for school aged children, sometimes the educable mentally retarded, and inservice training for teachers.

4. ADMISSION/DISCHARGE PROCEDURES

This section of the paper reports on the admission criteria used by the programs, the types of clients that are excluded from service, the basis of decisions to discharge clients, the proportion of cases readmitted and those that drop out and the size of waiting lists as reported by the programs.

4.1 Admission Criteria

A number of different criteria are used by the programs to determine if a client is eligible for service. Most programs use a combination of the following:

Place of Residence:

Three programs mentioned a defined geographic area within which clients must reside. For one program, only residents of a nursing home are eligible for service.

Age:

As described under Section 3. Mandate, programs serve different age groups and often admit only preschoolers or children.

Enrolment in Other Programs:

Programs sponsored by Associations for the Mentally Retarded require clients to be enrolled in another program operated by the Association to qualify for communication services.

A criterion used by some programs is that the client is not able to obtain communication services from other agencies.

Severity of Disability:

The most generally used criterion is a diagnosis of mental retardation or other assessments to determine the severity of disability. Significant delay in communication or a severe communication disorder are assessed and the results of psychological and hearing tests are often used to determine eligibility. For younger clients, admission can be made on the basis that the child is "at risk" for, or demonstrating, language delay and/or communication impairment.

Expectation of Improvement:

Often, therapists use their clinical judgement to determine if the client's communication is likely to improve before a client is accepted into the program. Four programs include as a criterion that the client has a reasonable prognosis for benefitting from services. Adult clients who are highly motivated and eager to work are admitted to some programs even though other criteria are not satisfied.

Involvement of A Mediator:

Some programs require the active participation of a naturally occurring mediator in implementation of the program before accepting clients.

Consent:

Referrals are usually in writing and parents/guardians must agree to the clients participation in most programs.

4.2 Exclusions

Programs exclude potential clients in accordance with the admission criteria listed above. Some programs do not exclude any clients for assessment. The basis of decisions to exclude clients from ongoing service provision vary from program to program. The type of clients that are excluded from individual programs include:

- those receiving services from another agency, particularly children in school settings where speech and language services are available;
- virtually all adults and most possible new cases over age 8;
- clients with poorly motivated parents;
- mentally handicapped individuals with interferring psycho- social problems;
- previously served clients who failed to benefit from appropriate treatment; and
- clients whose communication skills are consistent with their overall functioning level.

4.3 Discharge Policies and Procedures

Only five of the programs have written discharge procedures. Generally the decision to discharge a client is made at the discretion of the clinician. Reasons for discharge include:

- goals are achieved;
- client moves from the area;
- child leaves the program because of age;
- non-compliance on the part of the client/family;
- lack of progress;
- time limitation (in some programs, intervention is provided in time blocks of 3 months; in another program, service is discontinued if no progress is made over a 2-year period.)

4.4 Readmissions, Drop Outs and Waiting Lists

Readmissions

Three programs reported readmissions during the past 12 month period. For these programs the numbers of readmissions are very few with the exception of the program that provides a specialized assessment service. In this case, 20 - 25% of the cases were communication and audiology reassessments.

Drop Outs

Eight programs reported that clients had dropped out of the program in the last 12 months. Again the numbers involved represented a small percentage of the case load. The reasons given for dropping out included:

- moving out of the area;
- client/ mediator not interested in continuing program;
- transportation problem; and
- no demonstrated benefit from therapy.

Waiting Lists

Eleven of the programs reported that they have a waiting list. One program divided its waiting list into separate lists for assessment and treatment; one divided it into speech pathology and audiology and three programs distinguished between preschoolers, school aged children and/or adults on the waiting list.

A total of 526 individuals have been identified as waiting for services from the communication programs. Of these the majority are estimated to be children. However, of the 196 individuals on the waiting lists reported by programs that segregate their waiting lists by age, 39 are preschoolers, 67 school aged children and 63 are adults. This reflects the priority given to younger clients by the programs.

The average waiting time on the waiting list also varies by age and service. Assessments are usually provided within one to 6 months. In programs that have separate waiting lists by age, preschoolers receive services within 6 to 12 months but school aged children and adults wait up to 2 years. For the other programs, the average waiting period is one year, with the period ranging from 3 months in one program to 24 months in others.

5. SERVICE DELIVERY

This chapter provides a profile of how services are delivered by the programs. Descriptions of modes of service, frequency and duration of service, primary goals for clients, the psychometric characteristics of clients, assessment and training tools, discharge and follow-up procedures, and the programs' experience with using direct therapy and mediator models in providing service are included.

It should be noted that this information provided about service delivery is incomplete and subject to variations of interpretations. For example, one program was unable to provide statistics on service delivery because the speech pathologist position was vacant at the time of the review. Other programs use different categories to collect information. There are also differences in the interpretation of specific elements, such as primary goals. Often only percentages were provided because precise statistical information is not collected. These data limitations make it necessary to use statistical information throughout the remainder of this report as indicators of trends rather than exact measures.

5.1 Modes of Services

Programs were asked to identify from their current caseload, how many clients are receiving each of the following modes of services. Since a client may receive service through more than one modality, programs were able to choose more than one modality per client.

Tables 5.1 and 5.2 display the total number of programs that use each mode and the total number of clients served in that mode by all the programs reporting in that category. Table 5.1 describes modes of service for children while Table 5.2 describes modes of service for adults.

Table 5.1 Mode of Services to Children (under the age of 18)

	Programs (max. 12)	Clients No.	%
- joint programming with the mediator and the client in his or her home, school or place of work	11	333	36
- group programming for mediators only	7	201	21
- training with the mediator only	7	117	12
- direct therapy for the client only in his or her home, school or place of employment	3	68	7
- joint programming with the mediator and client in the centre	4	68	7
- direct therapy for the client only in the centre	2	20	2
- group programming for clients only	3	18	2

Other modes of service mentioned included:

Summer language Camp	1	68
Parent Support Group	2	45

Table 5.2

Mode of Services to Adults

	Programs (max.11)	Clients No.	%
- joint programming with the mediator and the client in his or her home, school or place of work	7	107	28
- direct therapy for the client only in his or her home, school or place of employment	5	47	12
- training with the mediator only	2	28	7
- joint programming with the mediator and client in the centre	2	13	3
- group programming for clients only	1	7	2
- group programming for mediators only	-	-	-
- direct therapy for the client only in the centre	-	-	-

Other modes reported include:

- speech, language, and hearing screening	2	145	38
- signing groups	1	30	8

The tables illustrate the extensive use of the mediator model approach by most of the programs in serving both children and adults. For nine of the programs, it is the predominant mode of service delivery for the majority of clients. However, in two programs relatively few clients are served by this mode.

The responses to the questionnaire also showed that some programs vary in the range of modes of service they provide. Two programs use as many as 6 different modes, but four others offer service in 2 modes only, joint programming with the mediator and client and mediator training. Services for children used a wider range of modes more frequently, but on average the programs used 4 different modes of service delivery.

5.2 Current Caseload

Frequency of Client Visits

Programs were asked to identify the level of frequency of current client visits separated by children and adults. The results are displayed below:

Table 5.3 Frequency of Visits for Children

	programs (max.12)	clients No.	%
- twice per week	1	8	1
- once every 1 - 2 weeks	12	269	37
- once every 3 - 4 weeks	6	68	9
- once every 1 - 2 months	7	265	37
- less frequently	8	113	16
		723	

Table 5.4

Frequency of Visits for Adults

	programs (max.11)	clients No.	%
- once every 1 - 2 weeks	6	65	35
- once every 3 - 4 weeks	4	12	6
- once every 1 - 2 months	4	14	8
- less frequently	3	95	51
		186	

The current caseloads for the 13 programs reporting the information show that 723 children and 186 adults for a total of 909 clients receive service. Combined with calculations based upon 'duration of service' reported below, it is estimated that approximately 1,300 clients are served annually at current levels of service. These totals should be used as indicators of the scope of the programs and not an accurate calculation of actual caseloads. Because accurate caseload numbers were often not available, some programs estimated the caseload and provided percentages; others provided only partial statistics.

Another difficulty in accurately determining an average caseload is the variety of modes of service that a program may be offering at any one time. For some recently established programs, much of the current effort is directed toward assessments. It is uncertain how frequently the program staff will visit clients once the assessment phase is complete.

The variation in the frequency of visits also reflects the different role of program staff in providing service: some provide regular direct service, others work with mediators, others provide consultation to front line workers and still others provide assessments only.

These variations make the calculation of an average caseload extremely difficult. An examination of the duration of service to the average client confirms this difficulty.

Duration of Service

Programs were asked to estimate the period of time that clients, whose cases were closed in the past twelve month period, received service. The results are shown below:

Table 5.5 Duration of Service

Period of Time	Programs (max. 9)	Clients No.
1 - 3 months	6	54
4 - 6 months	4	39
7 - 11 months	6	117
1 - 2 years	6	84
over 2 years	5	33
		327

Four programs that have been established recently had no experience with cases that were closed. Of the nine programs that were able to report on closed cases, it appears that approximately 50% of their caseloads are discharged each year.

The Ministry's guidelines for communication programs assumed that a typical case would last approximately four months on average. The average duration reported by the programs is more typically 12 months.

5.3 Primary Goals for Clients

From their estimates of their current caseload, programs were asked to categorize clients according to their primary goal. These are reported in Tables 5.6 and 5.7.

Table 5.6

Primary Goal	<u>Children</u>	Programs (max.12)	Clients No.	Z
- develop or improve prelinguistic (vocal or non vocal) communication behaviour		12	277	39
- develop and improve syntactical or semantic/grammatical functions		11	151	21
- develop and improve articulation or resonance		9	77	11
- develop communication through augmentative devices or techniques (Bliss boards, word boards, "Phonic Ear Handy-Voice", etc.)		11	75	11
- develop and improve interpersonal communication		6	45	6
- modify echoic, stereotypical or bizarre language behaviour into functional communication		8	43	6
- develop and improve confidence to communicate at one's level of ability		5	35	5
- develop fluency or reduce stuttering behaviour		0	0	0

Other goals mentioned were:

- auditory skills	3
- assessments only	2
- expansion of receptive and expressive language	1
- develop early linguistic behaviour	1
- feeding	2

Respondents commented on the distinction between goals, and expressed the view that the development and improvement of interpersonal communication skills are a part of any program but not necessarily the primary goal.

For children, the most common primary goals are the development or improvement of prelinguistic (vocal or non vocal) communication behaviour and syntactical or semantic/ grammatical functions. Almost all programs serve clients in these categories. No program considers the development of fluency or reduction of stuttering behaviour a primary goal for the children served.

While Table 5.6 reports on primary goals most programs have children with a variety of goals, usually clients fall into 6 different categories of the goals listed.

Unlike the primary goals for children, a wider variety of goals were identified for adults in total, as indicated in Table 5.7 below. However, there was less consistency among the programs, that is fewer programs were involved in providing assistance to reach a similar goal. In fact, a program serving adults has a more limited variety of goals, on average 3, for these clients. Seven of these programs serve less than 10 adults each, of these two serve only one adult client.

Table 5.7

Primary Goal	<u>Adults</u>		
	Programs (max.11)	Clients No.	%
- develop communication through augmentative devices or techniques (Bliss boards, word boards, "Phonic Ear Handy-Voice", etc.)	6	38	21
- develop and improve interpersonal skills	6	32	18
- develop or improve prelinguistic (vocal or non vocal) communication behaviour	2	27	15
- develop and improve confidence to communicate at one's level of ability	4	25	14
- develop and improve articulation or resonance	5	19	11
- develop and improve syntactical or semantic/ grammatical functions	3	14	8
- modify echoic, stereotypical or bizarre language behaviour into functional communication	2	14	8
- develop fluency or reduce stuttering behaviour	3	9	5
Other goals mentioned were:			
- voice	1	1	

5.4 CLIENT CHARACTERISTICS

Programs were asked to identify how many of their clients have a psychometrically confirmed diagnosis of developmental handicap.

Six programs reported that they did not know if their clients had a confirmed diagnosis. Two of these programs had medical diagnoses available and one program had psychological diagnoses for all clients.

Children are not always assessed psychometrically because:

- the developmental handicap is obvious;
- the lack of good psychometric assessments capability in the area; and
- the agency has a philosophy against labelling preschool children.

For those programs that do have psychometric assessments available, most of the clients have a confirmed diagnosis of developmental handicap or are awaiting diagnostic testing. Two programs reported that approximately 20% of their clients do not have a psychometrically confirmed diagnosis.

5.5 Assessment and Training Packages

Assessments

The Ministry's communication guidelines state that all proposals for communication programs should be designed to ensure that the receptive and expressive communication skills of all clients have been assessed. An examination of each client's natural communication environments, eye sight and hearing should also form part of this assessment approach.

The guidelines recommended the following assessment tools, but noted that there are many other appropriate scales available:

- a) general audiological screening
- b) demographic assessment of mediator-child communication pattern
- c) Reynell Developmental Scale
- d) Leiter
- e) Question Imitation Language Inventory (QILI)
- f) visual-tactile test.

Mediator receptivity should also be evaluated.

In the questionnaire, the programs were asked to identify which standard assessment packages they use and whether or not they use "home grown" assessment packages.

The responses provide an indication of the number of standard packages available. Forty different standard packages were identified. However, only six of the packages were mentioned by more than two programs.

The commonly used standard packages are:

- Test for Auditory Comprehension of Language
- Goldman Fristoe Test of Articulation
- Peabody Picture Vocabulary Test Revised
- Sequenced Inventory of Communication Development
- Reynell Language Development Scales
- Carrow Elicited Language Inventory

Nine of the programs reported that they used their own "home grown" assessment packages. The most frequently mentioned home grown tools were in the area of pragmatic assessment (functional communication), and interaction between parent and child.

Other home grown packages mentioned were in the areas of:

- screening for language observation,
- spontaneous articulation,
- feeding, and pre-linguistic skills,
- articulation,
- receptive language, expressive language,
- caregiver video assessment,
- oral-motor functioning, and
- determination of suitability for an augmentative means of communication.

Training or Instruction Packages

The programs were also asked to identify any standard training or programmed instruction packages they used. Although almost twenty different packages were mentioned, several programs use adaptations of these packages to meet their own needs. The most commonly used packages are:

- the Hanen Early Language Program or a modified Hanen approach,
- Fokes Sentence Builder, and
- Louise Kent's 'Language Acquisition Program for the Retarded or Multiply Impaired'

The Hanen program was the most frequently mentioned training package. The Hanen program stresses the involvement of mediators in the development of communication skills. It is an instructional package that teaches mediators how to become involved with the therapy in a natural setting. The course takes between 10 and 17 weeks to complete. This Hanen training package is often modified through ongoing evaluation.

Two programs, the Parent Programs in Language Intervention in Toronto and the Regional Human Communication Unit at Queen's University, Kingston, are particularly involved in using the Hanen approach to train professionals and parents about the mediator model.

Several programs use the Hanen Resource Centre in Toronto as a resource to train speech pathologists and other professionals such as public health nurses, day care workers, special education teachers and others, in the mediator approach. The Centre is a private organization which provides workshops, guidebooks, videotapes and newsletters for use by professionals in the field.

The programs were also asked the extent to which they used their own "home grown" training packages or curricula. Of the eleven programs that responded to this question, the majority reported that they used individual/client specific training packages more than 90% of the time. Only two programs used their own packages less than 25%.

5.6 Monitoring Clients' Progress

The Ministry's guidelines describe a process for planning and monitoring individual training and treatment. This plan referred to as the I.T.P. should be developed for every client. A prescriptive communication program (the I.T.P.) should be individually designed to facilitate the client's needs in the specific areas of development. It is intended that the training plan be developed in the context of the client's overall Individual Program Plan, with due consideration of the client's natural environment.

All I.T.P.'s should have time-dated objectives. A mechanism should be established to ensure that these objectives are reviewed systematically. In addition, consultation with other community resources should be used as a means of monitoring clients' progress.

As part of this review, programs were asked about the methods they use to monitor progress while the client is in the program. The programs reported using both formal and informal methods to monitor progress. Only two programs made specific reference to the I.T.P. but the elements of the process were mentioned by most programs. Methods used include:

- Ongoing data collection and reports:

- from home programs and therapy sessions,
- from mediators, and
- from any programmed instruction packages.

- Formal Reassessment including:

- re-evaluation of skills,
- pre-test and re-test using same measures,
- pre- and post- assessment of child by speech pathologist,
- pre- and post- assessment of child by parents,
- intelligibility tests,
- time samples depending on the goals, and
- probes of specific skill areas.

- Direct observation such as:

- listener evaluation of progress
- parental observation and feedback,
- mediator interviews,
- speech & language samples, and
- monitoring parents' ability to facilitate language development on

video tapes.

- Consultation through:

telephone contact,
case reviews,
teacher-parent consultations, and
liaison with other speech and language professionals involved
with client.

5.7 Follow-up after Discharge

Programs were asked about their procedures for following clients' progress after discharge. One program does not discharge a client if follow up is necessary, and another has not yet established a discharge policy. Most of the programs have established a procedure for follow-up on a routine basis with the client, the mediator, care-giver or other professionals such as school teachers.

The extent of follow-up is often at the discretion of the speech pathologist in consultation with the client and family. Programs usually encourage clients and parents/mediators to maintain ongoing contact through telephone calls, informal visits, or regular appointments. Some programs have a schedule for follow-up starting at once a month, then every 3 months and gradually fading to once every 6 months. Some programs have standard 6 month or 12 month recheck periods. In one program, the frequency of follow-up home visits is determined by the speech pathologist with a minimum of one visit every 3 months.

Some programs send discharge reports to the next service program, and use teacher monitoring and progress reviews as their means of follow-up.

5.8 Experiences with Different Approaches to Service Delivery

Because programs offer a variety of approaches to delivering services, the review was designed to explore their experiences with these different approaches.

Programs were asked to comment generally on approaches they had used in the past which did not work or with which they were not satisfied and to describe the main problems with them.

The responses from the programs touched on a variety of issues:

- Mediator program when it could not be monitored at least once monthly.
- Direct therapy with no mediator programming. It was reported that the client learned to use new communication only in the therapy setting and was unable to generalize teaching into the natural environment.
- Direct articulation therapy with the adult population. Using caregivers of adult clients to teach articulation skills was a problem because of the apparent lack of interest and frequent changes in personnel.
- Programmed instruction, such as Louise Kent's 'Language Acquisition Program for the Retarded or Multiply Impaired', are considered too rigid and do not allow for individual differences in children, individual reinforcement preferences and individual family/mediator support systems.
- Strict psycholinguistic approach was too narrow for effective programming.
- Workshops given to child caregivers prior to assessment of child were ineffective because the caregivers were unable to discuss the specific needs and problems of the client.
- Infrequent monitoring of programming suggestions presents a problem because often facilities do not know what action to take when problems arise.
- One specialized program that has recently begun training parents has found problems in involving teachers in joint training sessions.

Some of these issues were discussed in greater detail as programs reported on their specific experience in helping clients achieve goals and on the use of direct therapy and the mediator model approaches. The remainder of this chapter on service delivery summarizes the comments on these topics.

5.9 Experiences in Goal Attainment

Programs were asked to categorize client goals into those that were most successfully achieved and those that they had least success in achieving. The reasons for the extent of success in each case was also discussed.

Goals Most Frequently Achieved

Language development including interpersonal skills, semantics, syntax, morphology and pragmatics is considered by many to be the most successful achievement among the programs. This is particularly so for children. From the specific choice of goals listed in the questionnaire, the programs selected the following most frequently:

- develop and improve syntactical or semantic/grammatical functions
- develop or improve prelinguistic (vocal or non vocal) communication behaviour
- develop communication through augmentative devices or techniques (Bliss boards, word boards, "Phonic Ear Handy-Voice", etc.)
- develop and improve articulation or resonance

Two programs mentioned most success in their goals of training parents and others to be the prime agent of change. Whether parental involvement is process or result, most programs attributed their success to motivated mediators, committed staff, close monitoring, ample instruction methods and the planning for specific goals that are rewarded in everyday communication.

Goals Least Frequently Achieved

Many programs mentioned the difficulty in achieving goals with adult clients. Specific goals considered most difficult to achieve are:

- develop and improve articulation or resonance; and
- modify echoic, stereotypical or bizarre language behaviour into functional communication.

These goals were difficult to achieve because of the strongly ingrained speech patterns of clients at this age. This demonstrates the need to provide service at an early age and is one reason why many programs serve children only. The problem in finding motivated caregivers for adults compounds the difficulty in meeting the needs of this group.

Among programs serving children, individual programs mentioned difficulties in achieving specific goals. The following problems were mentioned in achieving certain goals:

- develop communication through augmentative devices or techniques, because of parental reluctance or disinterest regarding augmentative systems;
- develop or improve prelinguistic (vocal or non-vocal) communication behaviour among children who seem to be "stuck" at the prelinguistic level perhaps because neurological progress is not able to be documented or the child is developing other skill areas;
- develop and improve articulation or resonance among autistic children because of the lack of knowledge of their training needs; and
- correcting oral-muscular disorders because of the nature of the disorder and the lack of applicable research materials.

5.10 Direct Therapy

Speech therapy services have traditionally been provided in a clinic setting with the therapist working on a one to one relationship with the client. For some organizations in the province, the sponsors assumed that the addition of speech pathology to existing services would follow this traditional pattern. The expectation of clients and administration in these programs is for direct therapy.

The Ministry's guidelines included direct intervention as a component of the communication programs and gives the following description:

A member of the program staff works directly with the client to assess, evaluate and/or treat the client.

Twelve programs responded to questions regarding their use of direct therapy. As reported in Table 5.1 and 5.2 earlier, it is an infrequent mode of service delivery with developmentally handicapped clients. Generally it was used as a component of the service for certain stages in the program, for certain conditions and for certain clients. For some programs it is used in conjunction with mediator training for almost all cases on a continuing basis. This is particularly so in some preschool classroom settings, where the speech pathologist works with the child on a one to one basis for approximately 10 to 15 minutes per week. In other programs, direct therapy is used as a temporary service only.

The programs made the following comments about the circumstances in which they use direct therapy:

For certain client conditions:

- development and training in augmentative systems,
- presence of pathological disorder or other requiring intervention of a speech pathologist,
- initially in voice therapy,
- essential for fluency, voice or oral/motor disorders.
- dyslexia

In certain client settings:

- ARC industries and other workshops,
- some school settings, especially for younger school aged children,
- initial preschool home visit.

For assessment and diagnosis:

- long term assessments;
- temporarily as a form of diagnostic therapy to determine best teaching approach and recommendations; and
- need for long trial period to determine appropriate mediator training

Associated with mediator model:

- to teach mediators, establish programs, validate progress, assessment, change or update goals,
- demonstration to mediator,
- community training programs, parent training, remedial therapy, group training for communication and social interaction,
- as precursor to mediator training,
- where parents are unable to become mediators,
- temporary until a caregiver can be located and trained,
- used only to model for a parent specific information she had difficulty in adapting for her child, and
- when mediator cannot be trained or is not available for trial therapy.

Programs viewed the following as the strengths of direct therapy:

- consistent monitoring of program and suitability to client,
- more opportunity for experimentation and flexibility,
- better able to use clinical judgement to modify or change programs,
- thoroughly trained individuals interacting with the client re: expectations, reinforcements, future goals,
- good for very specific speech and language programs,
- immediate adaptation of program when needed,
- more realistic goals can be set for mediators,
- some cases are too difficult for mediator intervention,
- faster results with intensive therapy,
- as a support to teachers and other professionals involved,
- demonstration to teachers regarding specific objectives of the child's overall development program,
- able to monitor growth progress and to achieve goals,
- information obtained is required for mediator training,
- direct therapy with the mediator observing is the best form of mediator training,
- the professional can modify the program at very regular intervals and can anticipate the direction therapy should follow,
- the therapist can respond to unexpected difficulties.

5.11 The Mediator Model

The Ministry's communication guidelines assume that all communication programs are designed to use the mediator model in delivering services. Under the section entitled Program Components the guidelines state that:

A member of the program staff provides instructions and training to an environmental mediator who then works directly with the client. In the course of mediator training, it is sometimes necessary for the staff member to work directly with the client to demonstrate a particular approach or technique to the mediator.

The mediator may be a parent, teacher or significant other in the client's environment. One program preferred to use the term facilitator.

Programs were asked to identify those conditions where they use the mediator model.

Of the twelve programs answering this question:

- 7 reported that they always use the mediator model;
- 3 use it whenever possible;
- 1 uses it in group- settings in nursery schools, and
- 1 when the waiting list does not permit enrolment in direct therapy.

Among the programs that always use the mediator model, direct therapy is sometimes added to this model, but the mediator model is the primary model. Specific conditions mentioned for the use of the mediator model were: prelinguistic intervention, when basic communication patterns need to be learned, drill for articulation correction, and use of new communication systems in daily living situation.

For those programs using the mediator model whenever possible, motivation on the part of the mediator is considered essential. Usually parents enter these program knowing and agreeing to become involved in some aspect of the programming for their children.

Strengths of the Mediator Model

Programs identified the strengths of the mediator model in terms of its effectiveness, the positive effect on the client's progress, as well as efficiency, the numbers served and the appropriate use of clinician's time and efforts.

Comments on effectiveness included:

- the strength in this approach is the positive effect on language learning when intervention is begun early and includes parent participation;
- because communication is a 24-hour proposition, intervention should also be the same;
- the mediator model (when the mediators are well trained) allows the client to learn communication in his/her environment as the situations occur, where the communication is needed;
- more functional communication strategies can be employed;
- use of naturally occurring speech/language models facilitates acquisition of skills;
- consistent programming can be provided in all the child's environments; and
- the model allows communication training through a variety of experiences.

The mediator model is also regarded by some as an efficient means of providing service. This was evidenced by the following comments:

- it reaches a maximum number of clients. For example, more children can benefit in a class where the teacher is a mediator.
- efficient use of clinician's time;
- although the speech-language pathologist is primarily responsible for pre-test, re-test, post-test, follow-up and progress reports, the strength of carryover comes through daily contact between client and mediator. Capable teachers, parents, supervisors and significant others who are concerned with the client's communication can usually follow program suggestions.
- shows clients and caregivers how to improve their interpersonal communication and reduces professional 'mystique';
- continuation and reinforcement of achievements in treatment after contact with clinician is discontinued; and
- client performance not affected adversely by strange (clinical) surroundings.

Problems with the Mediator Model

Despite the advantages of the model, most programs had experienced infrequent situations where the mediator model was tried but failed. These types of situations are generally when the parent or other caregiver is either unable or unwilling to devote sufficient effort to the role of mediator. As mentioned previously, this is a particular problem with adult clients, but for parents of developmentally handicapped children, their own personal situation affects their involvement in the program. Commonly mentioned problems include:

- transportation problems. Due to distance involved, one program could not be monitored more often than every 6 weeks.
- lack of parental interest and commitment. In some situations, parents believe communication programs can only be offered by professionals and it is difficult to convince them that the mediator model is the appropriate approach
- some parents are too burdened to assume the commitment necessary to become effective language facilitators, for example, working parents or parents suffering mental illness, marriage breakdown or more pressing medical needs, are sometimes unable to serve as mediators;
- the parents first language is different or impaired;
- parents themselves have too low a cognitive level to follow the program satisfactorily;
- parents of older autistic children.
- lack of co-operation on caregivers' part, for example some programs have difficulty enlisting the support of some teachers;
- when the child's handicap is so severe that positive change is extremely difficult

Several programs mentioned the problem of parent 'burnout' in relation to the mediator program itself. There were too many goals expected at once, so that planned strategies become effortful rather than routine. The programs were able to correct these situations by reducing and simplifying the goals with the mediators and redesigning programs to be more consistent with daily routines.

For most programs problems with the mediator model are very infrequent. Only two programs reported a significant number of situations where the mediator model was tried but failed. Some of the programs that reported very infrequent problems noted that the cases are carefully screened for appropriateness of the mediator model.

The programs use three different methods to handle situations in which the mediator model failed:

- refer client to another agency and in effect, terminate the case;
- change focus of therapy usually to direct therapy, but sometimes to peer group therapy, or consultative therapy;
- maintain mediator model, but increase time spent in training and education of existing mediator, more frequent monitoring of goals and programming or arrange for alternative mediator.

Although 3 programs are more likely to terminate clients than change the focus of therapy or the mediator, usually all three methods are tried by each program, depending on the situation.

5.12 Groups Requiring Service

Nine of the programs are aware of groups of clients in the community who should or could be using their service but are not. Specific groups mentioned are:

- "at risk" infants
- students in the senior school for the retarded;
- developmentally handicapped adults
- developmentally handicapped adolescents
- clients in rural areas
- clients without mediators
- children with hearing impaired parents,
- children who are not diagnosed as developmentally handicapped but who have speech and language problems,
- francophone children
- clients coming out of institutions and into the community

6. RESOURCES FOR COMMUNICATION PROGRAMS

The Ministry's guidelines suggested a staffing structure that included a program director or equivalent, front line staff and possibly a program secretary. The staffing ratios recommended were:

- for a front-line worker: a case load of 7 - 9 active cases;
- a program director would carry 1/4 to 1/2 as many cases as a front line worker, or as many cases as administrative duties allow.

A typical case was expected to last approximately four months on the average. Therefore in one 12 month period, one front line worker could potentially handle approximately 25 -35 cases.

For facility requirements, the guidelines recommended that if an "in - centre" facility is to be used in the direct provision of service to clients aged 2 - 18, the building and equipment specifications as detailed in the Day Nurseries Act should be consulted. Further, it was recommended that no more than five such clients be involved in in-centre programming activities at one time. The guidelines did not refer to the supplies or technical equipment resources to be included in communication programs.

This review of the existing programs found that the resources available to communication programs in the province differ. When examining these differences it is important to recall the differences in sponsorship, mandate, services delivery practices and caseloads.

6.1 Staff Resources

Staff to Client Ratios

As mentioned in the discussion on caseloads in the chapter on service delivery, it is very difficult to calculate an average caseload among these programs.

In total the programs have a caseload of approximately 900 clients and have a staff of 45.9 full time equivalents (FTE). However, one program serves a clientele of 200 with a staff of 2. At the time of the review, this program was limiting its services to screening and assessing clients.

Another program which receives funding from a variety of sources, has the expertise of 12 members of a multidisciplinary team available to serve 50 clients. These are the extremes. After excluding these extremes, the review found a wide range of reported caseloads.

The ratio of total full time staff to total clients in the thirteen of the programs are as follow:

1:4, 1:7.6, 1:11, 1:12.5, 1:15, 1:16, 1:20, 1:21, 1:25, 1:35, 1:38, 1:39, and 1:100.

Staffing Patterns

Management structures vary among the programs, depending on the size of the program and the organization sponsoring the program. In five programs the director carries a full caseload, either as the sole employee of the program (3) or as the team leader (2). Of the nine programs where the director does not carry a caseload, 3 manage only the communication program (one on a part time basis) and the other 7 have responsibility for other programs within the organization.

Most of the staff of the programs (24 of the 46) are professionals with training in speech pathology to the Master's level and qualify for membership in the Ontario Speech and Hearing Association. Other professionals employed by the programs include audiologists, social workers, psychometrist, psycholinguist and teachers with certificates in early childhood education.

In addition to the speech pathologists, four programs employ speech assistants who work directly with the client and mediator on a day to day basis. There are a total of 10 assistants (FTE) in these 4 programs, one program employs parents, and the others hire individuals who have community college or university training.

Only a few programs have secretarial staff as part of the program.

Hiring Practices

Since professional credentials are a prerequisite for most positions, and since few individuals trained in speech pathology have experience in working with developmentally handicapped persons, such experience is not usually a criterion for employment.

The programs emphasized the importance of interpersonal skills, particularly the ability to work well with clients, mediators and other staff members. Other skills such as initiative, independence and creative abilities were also mentioned as attributes desired in hiring staff.

Salary Compensation

Salaries reported by programs for speech pathologists range from a low of \$20,000 per annum to a high of \$35,000. The salary ranges for most speech pathologists and other professional staff average \$24,600 to \$28,700. Average salaries for assistants are in a range from \$14,400 to 21,100.

Use of Volunteers

Eight of the programs report using volunteers, generally only one. There are a variety of tasks, program and clerical, that volunteers perform including:

- review of program material with client,
- articulation program with discharged client,
- small group program working with 9 - 16 year old autistic clients working on improving communication and social interaction skills, and use of community resources;
- mediator model therapy;
- assist during hearing tests;
- interpretation services;
- clerical, developing filing systems for therapy materials and parent education programs, computer entries, assisting in the development of therapy and assessment materials; and
- filing, collating, assembling material, photostat, researching, collecting statistics.

Staff Activities

The programs were asked to estimate the percentage of paid staff time is devoted to certain activities. Table 6.1 provides a composite of their responses.

Table 6.1

<u>Activity</u>	<u>% of time</u>
- case planning and review (IPP), report writing/ record keeping	25.1
- joint programming with the mediator and client	16.3
- direct therapy	10.0
- staff supervision and administration	10.0
- travel	9.0
- inservice training/ staff development	8.8
- assessment	7.6
- consultation to and staff training in other agencies	5.2
- general community education (eg. public)	4.3
- other (research and special projects) presentations)	3.7

Staff Training Needs

All programs mentioned the need for staff training. Areas requiring specific staff development include:

- working with autistic clients, adults and children.
- adaptation of battery-operated toys to micro switches, etc.
- upgrading programs for speech and language assistants
- augmentative systems, i.e. signing, Bliss, feeding, articulation therapy
- new assessment/treatment approaches, research techniques, clinical computer applications
- filing systems, use of dictaphone.
- technical use of video, packaging editing, etc.

Several programs mentioned that continuing professional development in all areas -- clinical, mediator, and assessment -- were essential and continuing update is required. This is particularly so in the case of skills related to parent education, support and counselling as well as professional expertise.

Staff training monies are limited in most programs, but the staff consider attendance at conferences and workshops as necessary activities to stay informed of current developments in the field, and to meet with peers.

Staff Turnover

In the last two years 12 programs had experienced some staff turnover. Usually one or two staff had left each program. Reasons for leaving included:

- taking a position in the school system
- working with autistic children
- promotion
- higher salary
- return to school
- desire to do more research
- maternity
- geographic preference
- dissatisfaction with organization

Programs were concerned about the difficulty in attracting staff. One program was without any speech pathologist when the review was conducted. In another program a position, which had originally taken 10 months to fill, had been vacant for 3 months.

6.2 Financial Resources

The total cost for these communication programs is approximately one million dollars. The "average" program budget is approximately \$78,000.00 in 1983/84, but the costs range from \$17,500 to \$181,000.

The source of these funds is almost completely from the Ministry of Community and Social Services. One program receives funding from the Ministry of Health, but the amount of this funding is not known.

Four programs receive additional funds through donations, fund raising projects and/or membership fees. One program raises as much as \$7,000.00 from these sources, but generally the level of private contributions is small.

Non-Salary Components of Budgets

The programs were not requested to provide specific information about the non-salary components of their budgets, but from the discussion with staff it is evident that there are wide variations in the funds available for expenditures such as:

- staff development,
- employee benefit packages,
- advice from outside consulting professionals,
- assessment packages,
- supplies, telephones and other office expenses, and
- specialized equipment such as video machines and computers.

The following specific examples illustrate these variations:

Staff development budgets are often reduced to meet deficits in some programs while other programs receive additional funds for staff development from the sponsoring organization.

In one program two speech pathologists share the same assessment kit because the budget does not allow for the purchase of a second one. In other programs there is easy access to library and research facilities.

Two programs use video equipment as part of the learning process for mediators, one has a computer for record keeping. The programs were able to purchase special equipment by using funds budgetted for salaries but available for equipment because replacement staff could not be recruited.

7. PROGRAM EVALUATION

Program evaluation is a process to determine how well a program is achieving its objectives, that is how effective it is, and also to determine how efficiently it is using its resources to accomplish its objectives.

The Ministry's Communication guidelines recommended that mechanisms for evaluating the effectiveness of each program should be developed. They suggest that this may be accomplished in a variety of ways, for example, establishing an advisory committee of community resource people, a systematic review of statistical data, etc.

7.1 Effectiveness Measures

As part of this review, the programs were asked what indicators of overall program effectiveness they use. Responses included:

- consumer satisfaction (client, parent, mediator, other agency, own agency staff),
- peer review,
- program supervisor review,
- staff evaluations, including staff performance appraisals and staff reports on strengths and weaknesses of program,
- client compliance,
- progress reports,
- chart audits,
- case conference reviews,
- goals achieved as established in client IPP and
- number of cases discharged having made documented progress.

Programs differ on the methods used to collect evaluation data. Feedback from staff and clients is often informal. Advisory committees are a source of community feedback for several programs. Other programs conduct formal evaluations and use structured pre- and post- service questionnaires. One program was concerned that no formal evaluation had ever been carried out or requested by the program's sponsor.

Client progress reports, consumer feedback, peer reviews, and professional satisfaction were generally considered most useful in providing the programs with guidance in regard to overall program effectiveness.

7.2 Efficiency Measures

Programs were also asked about the indicators they use to measure the efficiency of providing service. Their responses show that there are no standard tools to measure the efficiency of program delivery.

Three programs have developed systems for detailed monitoring of activities and costs. Many of the other programs are beginning to use statistical information to monitor program activities, but most reported that they had no measures of efficiency. Some programs were unable to distinguish between measures of program efficiency and effectiveness. Others were looking for assistance in developing measures of efficiency of service delivery practices.

For those that had considered changing service delivery practices to increase efficiency, there was concern that quality and therefore effectiveness might suffer. Some programs are uncertain that the mediator model is cost effective and others are considering the program implications of hiring assistants for speech pathologists.

8. REPORTING REQUIREMENTS

The communication guidelines contain a section on documentation. It specifies that each program should have a systematic method of data collection that includes each client's individual training/treatment plan. The client's files should adequately reflect the client's program and progress within the program.

8.1 Client Files

To determine the extent of documentation, the questionnaire asked the programs to identify which of the following types of documentation the program collects on each case. The respondents were asked to indicate the percentage of client files where, if a file audit was conducted, they would expect to find the documentation present and up-to-date. Table 8.1 is the composite of the responses to this question. The number of programs responding that their files would contain the information and the average of the percentages reported by these programs is shown.

Table 8.1

Data	Programs (max.14)	Percentage of files
Referral form	12	100
Progress notes	14	99
Assessment report	14	92
Termination summary	13	88
Individual treatment plan	13	83
Medical report	9	78
Mediator training plan	10	67
Family history	14	61
Formal follow-up data	4	60

other documentation mentioned included:

Contact sheet	3	100
Consent forms	3	98
conference reviews	2	80
audiological reports	3	40

Several programs reported that portions of the client's files are in the main casebook file book for the agency. Some programs maintain documentation of specific activities such as video tape samples and analysis. The extent of documentation also varies according to the client group. For example, medical reports are more frequently maintained for children than adults.

8.2 Information Reports to the Ministry

Programs were asked about the type of information reported and frequency of reports to the Ministry's Program Supervisor.

Ten programs report information about the program to the Ministry's program supervisor. Seven provide quarterly statistics on the numbers of clients served and a description of the program status. Some of these reports are quite extensive, with both client data (age, sex, disability, referral source, and reason for referral) and program information (number of client contacts, resource contacts, consultations, significant developments, education support, and community liaison activities). Three programs make informal reports when requested by the program supervisor or on their own initiative.

Four of the respondents have not reported any information to the Ministry's program supervisor.

8.3 Directions and Guidelines from the Ministry

Half of the programs reported that they receive direction and guidance from the Ministry's Program Supervisor or other staff of the area office on a regular, ongoing basis. Contact is made during personal visits, group meetings, and through memos and telephone conversations. Issues discussed include philosophy of service, directions toward future proposal, changes in focus, policies and procedures, community linkages, budget preparation, program monitoring and evaluation systems.

9. COMMUNITY RELATIONSHIPS

As community-based programs serving the developmentally handicapped, these communication programs are designed to function as part of a support network with other agencies in the community.

In the communication guidelines, consultation and public education are specifically mentioned components of the programs. In the consultation component, a member of the program staff provides advice or suggestions to another professional working with the client. In public education activities, the program provides general information regarding developmental handicap and language development to the community at large.

The programs were asked about the type of co-ordination that exists between their program and other agencies in their communities.

9.1 Other Agencies

All fourteen programs reported a variety of activities involving other community agencies. These agencies include:

- associations for the mentally retarded,
- boards of education,
- children's aid societies,
- public health departments,
- social service agencies,
- family support workers,
- day care centres and nursery schools,
- group homes,
- ARC Industries and other sheltered workshops,
- children and infant developmental centres,
- hospitals,
- assessment agencies,
- adult protective service workers,
- behaviour management services,
- Ontario Crippled Children's Centre,
- The Hanen Program,
- The Canadian Hearing Society and
- The Speech Foundation of Ontario.

9.2 Mechanisms for Co-ordination

In some areas of the province, co-ordination mechanisms are well established to bring together professionals serving the developmentally handicapped in the community.

The monthly meetings of community support program co-ordinators in Ottawa and the ad hoc Speech Advisory Committee in York Region are specific examples. As one of its functions, the program in Kingston is in contact with other agencies to encourage development of more services in the area.

The case conference is another device used to co-ordinate services among professionals serving the same client but employed by different agencies. Some speech pathologists report difficulty in being routinely invited to these conferences.

The co-ordination among agency staff usually centres on individual client cases: referrals, consultation, case co-ordination, support and follow-up. Mediator participation and parent training programs are sometimes conducted in co-ordination with other programs. A few programs also provide inservice training sessions for staff of other agencies.

Although early identification is considered important in improving communication, few programs mentioned any involvement in co-ordinating education programs for the general public.

9.3 Role of Case Manager

Often clients and their families need a variety of support services in the community. The programs were asked if their staff served as a case manager or advocate for clients.

Eight replied that they did not fill this role. Of the six that did become involved in arranging other services, two reported that their involvement was in advocating for special services and that this was rare. One had the role by default, when other case managers (family support or adult protective service workers) were not available.

Three of the programs were involved in many aspects of the support services requested by the families. Respondents from these programs made the following comments about this role:

- Parents feel very positive about their involvement with our programs, they trust the organization to act as an advocate for services.
- Because we are independent we have consistent contact with families. This helps identify needs. We also have knowledge of community resources and we view ourselves as providers of parent support. Parents trust us and request this service [case manager] from us and view the counsellors as their advocates
- We assume this role due to the degree of our involvement, expertise and interagency contact.

Appendices:

- A. Ministry's 1977 Communication Guidelines**
- B. Respondants Names, Agencies and Addresses**
- C. Communication Program Questionnaire**

Appendix A

COMMUNICATION GUIDELINES

Purpose

A communication intervention program is designed to assist any developmentally handicapped person aged two and over, who is communicatively impaired to attain their developmental potential.

Definition

The goal of communication intervention is to identify each client's particular level of language/cognitive development and through appropriate curriculum programming, to facilitate the client's attainment of the next successive stage of development. The type of program for clients taking part in a communication program will vary depending upon their communication skills. Therefore, an awareness of the sequence of language/cognitive development is necessary. The following stages of language/cognitive development are sequential and should be considered outside of a chronological or age specific time table.

i) Prelinguistic Vocalization

1. biologically "reflexive" vocal/gestural activity - serves to indicate affective and conative states
2. responds differentially to patterning of sounds (intonation) and individual sounds (babbling)
3. responds in imitation of human sounds (imitative babbling)
 - development of object permanence
 - vocal activity now serves cognitive and social functions
4. representational imitation occurs in the absence of the object
 - i.e., emergence of symbolic function

ii) Single Word Utterances

The "first word(s)" may be interpreted as signifying an object(s) and its properties together with the actions with which it is associated. Thus, to interpret the "meaning" of single word utterance, one must also examine the context in which the word is produced and also the speaker's paralinguistic behaviours. Initial words may be considered conceptual representations of regularly occurring events.

iii) Two and Three Word Utterances

Early linguistic development occurs by one-word accretions up from one to two and finally to three-word utterances. Increases beyond this period are not determined by one-word additions, rather through the application of grammatical rules not determined by the "here and now".

Two-word utterances function to describe or make assertions about actions and states of the physical world which the speaker directly perceives (e.g., possession, location, attribution, existence, action, etc.).

The richness of the speaker's cognition is still not fully captured linguistically

- i.e., listener still required the extra linguistic context.

iv) The Sentence

The comprehension and expression of sentences reflect the emergence of an underlying system of grammatical rules not determined by the "here and now". The question now becomes one of relating how and whether the available cognitive structures and processes are served by this system. (e.g., consideration should be given to stuttering, articulation, etc.).

Program Objectives

All proposals for communication programs should be designed to:

- a) assess and evaluate eyesight, hearing, receptive and expressive communication;
- b) assess and evaluate the client's natural communication environments and the nature of the client-mediator interaction;
- c) facilitate the development of communication skills through programming;
- d) provide mediator training;
- e) provide mediator education;
- f) provide liaison with other community resources by referral and/or consultation;

Program proposals may also be designed to meet some/all of the following objectives:

- g) remediate physical impairments affecting sight and/or hearing through adaptive equipment where financially feasible;
- h) develop novel assessment, treatment and training methods and materials;
- i) develop new evaluation tools;
- j) provide training to community agents;
- k) provide public education;
- l) provide practical training.

Curriculum Content

The following components are cumulatively related to the stages of language/cognitive development presented above.

a) Perceptual Motor Development

Refers to the ability to coordinate perceptual and motor behaviour and thereby either respond appropriately to incoming sensory stimulation or engage spontaneously in the effective goal-directed performance of an act. The goal of the perceptual motor aspect of the communication curriculum is to provide a wide range of experience to guide the development of visual and auditory perceptual acuity, discrimination, skills, etc. Programming should also include a language environment of questions and instructions conducive to the development of the comprehension and expressive skills required to carry out these activities (through listening training, attention training, vocabulary, sentence reduction and elaboration, etc.).

b) Cognitive Development

Cognitive Development is viewed as the degree of knowledge that the child possesses at any given time, and the techniques and strategies that the child uses to acquire that knowledge. To facilitate cognitive development, the curriculum should include:

1. Appropriate manipulative and multi-sensory problem solving materials (e.g., toys, puzzles, wood lottos, etc.) to serve as a basis for two-person or group play.
2. A wide range of problem solving situations within the child's natural average environment requiring interaction between himself and/or more persons.
3. Specific activities exploring the relationships between the physical spacial and temporal futures of objects and the language appropriate to their use and description.
4. Activities to introduce further symbolic representation.

c) Self Care Skills

Refers to an individual's ability to attend to his or her immediate needs, either physical or psychological. Dressing, bathing, toilet training and awareness of danger are some primary examples.

d) Social Skills

Refers to a wide range of processes and behaviours which may vary from smiling to highly complex interaction. Social skills may be divided into social responsiveness and impulse control.

Program Components

a) Assessment

All proposals for communication programs should be designed to ensure that the receptive and expressive communication skills of all clients have been assessed. An examination of each client's natural communication environments, eye sight and hearing should also form part of this assessment approach.

The following assessment tools are recommended, however there are many other appropriate scales available:

- a) general audiological screening
- b) demographic assessment of mediator-child communication pattern
- c) Reynell Development Scale
- d) Leiter
- e) QILI (Question Imitation Language Inventory)
- f) visual-tactile test. Mediator receptivity should also be evaluated.

b) Individual Training/Treatment Plan (I.T.P.)

A prescriptive intervention program as reflected in the I.T.P. should be developed for every client. A prescriptive communication program (I.T.P.) should be individually designed to facilitate the child's needs in the specific areas of development. This I.T.P. must be developed in the context of the child's overall Individual Program Plan with due consideration to the nature of the child's natural environment.

All I.T.P.'s should have time-dated objectives. A mechanism should be established to ensure that these objectives are reviewed systematically.

In addition, the following program concepts may be included:

- a) to provide liaison with other community resources by referral and/or consultation
- b) to develop novel assessment, treatment and training methods and materials
- c) to develop new evaluation tools
- d) to provide training to community agents

c) Mediator Training Plan

A member of the program staff provides instructions and training to an environmental mediator who then works directly with the client. In the course of mediator training, it is sometimes necessary for the staff member to work directly with the clients to demonstrate a particular approach or technique to the mediator.

d) Direct Intervention

A member of the program staff works directly with the client to assess, evaluate and/or treat the client.

e) Group Training

The staff member(s) train several mediators simultaneously in the group context.

f) Consultation

A member of program staff provides advice or suggestions to another professional working with the client. In the consultation model, the staff member works directly with the client and/or mediator on a one session basis with follow-up being encouraged.

g) Public Education

A program member provides general information regarding developmental handicap and language development to the community at large.

Documentation

Every Individual Training/Treatment Plan must be accompanied by a systematic method of data collection. The client's files should adequately reflect the client's program and progress within the program.

Staffing Structure

a) Position Description:

Core program staff should include a program director or equivalent and front line staff. A program secretary may be necessary.

b) Staffing Ratios:

A front-line worker should carry a case load of 7-9 active cases. It is recommended that a program director carry ¼ to ½ as many cases as a front line worker, or as many cases as his/her administrative duties allow.

A typical case can be expected to last approximately four months on the average. Therefore in one 12 month period, one front line worker could potentially handle approximately 25-35 cases.

c) Facility Requirements

If an "in-centre" facility is to be used in the direct provision of service to clients aged 2-18, the building and equipment specifications as detailed in the Day Nurseries Act should be consulted. Further, it is recommended that no more than five such clients be involved in in-centre group programming activities at one time.

Program Evaluation

A mechanism for evaluating the effectiveness of the program should be developed. This may be accomplished in a variety of ways (e.g., establishing an advisory committee of community resource people, a systematic review of statistical data, etc.).

In addition, a periodic program review and evaluation will be conducted as and when the Ministry deems necessary.

Requirements for Funding

Any non-profit incorporated body may apply for funding of a communication program. If an adequate number of clients who need a communication program has been identified, the Mental Retardation Co-ordinator in the appropriate area should be contacted. He/she will assist you in the preparation of the proposal. The proposal must then be submitted to the Direct Working Group who will review the proposal in the light of the Community Needs Analysis and District Plan.

Legislative Authority

Most components of communication projects may be funded under the Developmental Services Act, 2(b) and/or Section 6 (d) of the Ministry of Community and Social Services Act. Where an in-centre treatment component is included, submissions will be advised to consult the standards as outlined in the Day Nurseries Act.

It is suggested that applicants familiarize themselves with the relevant portions of these acts prior to formulating their proposal.

GLOSSARY

Articulation

The clarity with which the individual components in an utterance are expressed.

Audiologist

Refers to a person trained in the non-medical assessment, habilitation and rehabilitation of disorders of hearing. He/she is also interested in the study of communication, both normal and impaired, as it relates to hearing and the processing of auditory stimuli.

Audiology

A branch of science dealing with hearing assessment and therapy.

Communication

Refers to the act or process whereby meaningful information is successfully transmitted from one person to another person. This meaningful information may be transmitted by verbal and/or non-verbal systems.

Communication Assessment

Refers to the measurement of a person's ability to both comprehend and express meaningful verbal and/or non-verbal information. A communication assessment should be based on standardized psychological and/or speech measurement instruments where possible. Where a standardized instrument is not used, a detailed description should be provided of the actual assessment procedure which is used (diagnostic assessment).

Communication Handicapped

Refers to persons who demonstrate any of the traditional speech problems (e.g., articulation, aphasia, etc.) and/or a communication ability which is normatively different and/or chronologically delayed.

Communication Program

Refers to an educationally based program designed to teach verbal and/or non-verbal communication skills. Such a program can range in application from a single individual to groups who are normatively different and/or chronologically delayed. Mediator education and/or training may also be involved.

Comprehension

Refers to the ability of an individual to understand verbal and/or non-verbal information transmitted to him. Comprehension refers to the possession of functional receptive skills.

Deaf-Blind

A person will be classified as deaf-blind when:

- a) the hearing loss is 'severe' (loss of 60-74 decibels) or 'profound' (loss of 75 decibels or more) and when the visual impairment is within the terms of 'legal blindness' or when
- b) in the case of children, a combination of substantial hearing and visual loss causes extreme difficulty in learning. Generally speaking, a person will be considered deaf-blind when he is legally blind and when, with the best possible help, he cannot hear clearly enunciated connected speech in a one-to-one situation at more than three feet or one metre.

Evaluation

Refers to the measurement of stated program objectives through careful observation, appraisal and documentation. The evaluation model using pre-test, post-test and follow-up measurements is highly recommended where possible.

Hearing Loss

Hearing loss may be computed as a function of degree or percentage. (1) Degree 0-25 dB - Normal Limits; 25-50 dB - Mild; 50-70 dB - Moderate; 70-90 dB - Severe; 90+ Profound. Unilateral hearing losses are not considered to be a handicap to communication.

Language

Refers to any system of conventional and formalized symbols, signs or gestures, etc. used as a means of communicating thought, emotions, etc.

Legal Blindness

A person is considered 'blind' if the visual acuity in both eyes with proper refractive lenses is (20/200) or less with the Snellen Chart or equivalent or if the greatest diameter of the field of vision in both eyes is less than twenty degrees.

Linguistics

Refers to the science of language, including phonetics, phonology, morphology and syntax. The focus of linguistics is the study of the structure of language (syntax).

Mediator

Refers to parent(s), guardian(s), or other primary care giver(s), who is/are able to form an uninterrupted and enduring relationship with the client and who has/have access to and control of the resources in the client's natural environment.

Mediator Education

Refers to the provision of general information regarding developmental handicap and language development or specific information regarding medical, social, dental and other issues.

Mediator Training

Refers to teaching the mediator to facilitate development of clients' communication skills; a variety of methods could be used to train mediators. Examples include: demonstrations, modelling, role playing, lectures, discussions, films, video tapes, etc.

Non-oral Communication

Refers to comprehensive and/or meaningful expression of information not contained in the spoken and/or written word. Non-verbal communication may include some/any of the following: symbol system, tele-touch systems, finger spelling, signing, one or two hand deaf-blind manuals, eye blink responses, natural gestures, Braille, etc.

Oral Communication

Refers to comprehensive and/or meaningful expression of the spoken/written word.

Program Director or Equivalent

Refers to the person who assumes ultimate responsibility for the financial, programming and direct service provided by the program.

Psychologist/Psycholinguist

A person holding a Ph.D degree of psychology and registered under the 1961 Psychology Act of Ontario and Who has a cognitive and/or language focus.

Psycholinguistics

The study of the cognitive basis of language.

Sign Instructor

A person who is fluent in the use of sign language.

Speech Correctionist

A person who has an Ontario Teaching Certificate and has successfully completed a supplementary short-term course in speech training.

Speech Pathologist

The Ontario Speech and Hearing Association defines a speech pathologist as a person engaged in the assessment, diagnosis, examination and treatment of and research in disorders of speech, voice and language formulation.

Vocalization

Refers to non-speech sounds.

Utterance

Refers to any act of communication consisting of one or more words, symbols, signs, etc. which is preceded and followed by a pause (or silence). It may be considered the same as a sentence.

1977 COMMUNICATIONS GUIDELINES COMMITTEE

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Surrey Place Centre

Mr. Allan Grills
Ministry of Community and Social Services

Dr. Mary Kanstantareas
Clarke Institute of Psychiatry

Ms. Jan McTurk
Ministry of Community and Social Services

Ms. Marna Ramsden
Ministry of Community and Social Services

Ms. Myra Rodrigues
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Appendix B

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000070

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Appendix C

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COMMUNICATIONS PROGRAMS QUESTIONNAIRE

Please complete this questionnaire and return it to Carolyn Sherk
by November 21, 1983. Thank you for your co-operation.

Name of Program _____

Name of Respondent _____

Position _____

A. GENERAL BACKGROUND INFORMATION

1) Date when your program began _____

2) Sponsoring organization

a) when program began _____

b) now, if different _____

c) please identify the advantages of being sponsored by this
particular type of organization

d) please identify the disadvantages of being sponsored by
this particular type of organization

B. PROGRAM MANDATE

1) What are the objectives of your service?

2) What services are you currently asked to provide which you do not feel are part of your mandate? For whom?

3) Why do you feel referral sources ask you to provide these services?

C. ADMISSION/DISCHARGE PROCEDURES

- 1) What criteria do you use to decide if a client is eligible for service?

- 2) What type of clients do you exclude?

- 3) How do you determine when a case should be terminated?

If you have a written procedure, may we have a copy?

- 4) During the past 12 month period:

- how many cases were readmissions to your program? _____
- how many cases dropped out? _____

- 5) What seem to be the major reasons for dropping out?

- 6) Does your program have a waiting list?

Yes _____ No _____

If yes, what is the current size of the waiting list? _____

What is the average waiting time on the waiting list? _____

D. CLIENT CHARACTERISTICS

1) In your current caseload how many clients:

- have a psychometrically confirmed diagnosis of developmental handicap? _____
- do not have a psychometrically confirmed diagnosis of developmental handicap _____

E. SERVICE DELIVERY

1) In your current caseload, how many clients are receiving each of the following modes of services? In some cases a client may be receiving service through more than one modality, please count each modality separately. (Please separate out by children and adults with a child defined as a person under the age of 18.)

	child	adult
- direct therapy for the client only in the centre	_____	_____
- direct therapy for the client only in his or her home, school or place of employment	_____	_____
- joint programming with the mediator and client in the centre	_____	_____
- joint programming with the mediator and the client in his or her home, school or place of work	_____	_____
- training with the mediator only	_____	_____
- group programming for clients only	_____	_____
- group programming for mediators only	_____	_____
- other, please specify _____		

- 2) Please indicate the number of current client visits, separated into adults and children (persons under age 18), at the following level of frequency.

	child	adult
- once every 1 - 2 weeks	_____	_____
- once every 3 - 4 weeks	_____	_____
- once every 1 - 2 months	_____	_____
- less frequently	_____	_____

- 3) For the cases closed in the past twelve month period, please estimate the number which received services for each of the following time durations:

1 - 3 months _____	1 - 2 years _____
4 - 6 months _____	over 2 years _____
7 - 11 months _____	

- 4) In your current caseload, how many clients have the following as their primary goal? Please separate by children and adults.

	child	adult
- develop or improve prelinguistic (vocal or non vocal) communication behaviour	_____	_____
- develop communication through augmentative devices or techniques (Bliss boards, word boards, "Phonic Ear Handy-Voice", etc.)	_____	_____
- develop and improve interpersonal communication	_____	_____
- develop and improve confidence to communicate at one's level of ability	_____	_____
- develop and improve articulation or resonance	_____	_____
- develop and improve syntactical or semantic/grammatical functions	_____	_____
- develop fluency or reduce stuttering behaviour	_____	_____
- modify echoic, stereotypical or bizarre language behaviour into functional communication	_____	_____
- other, please specify _____	_____	_____

- 5) What, if any, standard assessment packages do you use?

Do you use your own "home grown" assessment packages? In what areas?

- 6) What, if any, standard training or programmed instruction packages (eg. Hanen 10 week early language training program, Non Slip, Louise Kent's program) do you use?

To what extent do you use your own "home grown" training packages or curricula? _____ %

- 7) What methods do you use to monitor progress while the client is still in the program?

- 8) Once a client is discharged how is follow-up done?

- 9) What approaches, if any, have you used in the past which did not work or you were not satisfied with? What were the main problems with them?

10) What goals (e.g. those listed in question 4 of this section) do you believe that your program has most success with?

11) Why do you think your program has the most success with the above types of goals?

12) What types of goals does your program have least success with?

13) Why do you think that your program has least success with the above types of goals?

14) Under what conditions do you use direct therapy?

15) What do you view as the strengths of direct therapy?

16) Under what conditions do you use the mediator model?

17) What do you view as the strengths of the mediator model?

18) Have you had situations where the mediator model was tried but failed?

Yes _____ No _____

If yes, please identify the types of situations

How frequent are such situations?

19) How have you handled situations in which the mediator model failed?

20) Are you aware of any groups of clients in the community who should or could be using your service but are not?

Yes _____

No _____

Don't Know _____

If yes, what type of group?

F. STAFFING

1) How many paid staff do you have in your program?

- number of individuals _____

- number of Full-Time Equivalents (37.5 hours/week) _____

2) For each position, please specify total number of full time equivalents (FTE), professional/educational qualifications and annual salary range:

Position Title	FTE	Qualifications	Salary Range
----------------	-----	----------------	--------------

3) What do you look for when hiring paid staff? (e.g. experience, qualifications, personality characteristics).

4) Does the Director of the Program carry a caseload?

Yes _____ No _____

If yes, how many clients? _____

5) Does your program use volunteers?

Yes _____ No _____

If yes, how many do you have currently? _____
What sort of activities do you use them for? _____

If no, why not?

- 6) What percentage of paid staff time is devoted to the following activities:

Activity	% of time
- assessment	_____
- direct therapy	_____
- joint programming with the mediator and client	_____
- case planning and review (IPP), report writing/ record keeping	_____
- inservice training/ staff development	_____
- staff supervision and administration	_____
- travel	_____
- consultation to and staff training in other agencies	_____
- general community education (eg. public presentations)	_____
- other, please specify _____	_____

- 7) Do you have any staff training needs?

Yes _____ No _____

If yes, please describe _____

- 8) In the last two years what has been the staff turnover experience in your agency?

no one left _____

1 - 2 left _____

3 - 4 left _____

5 or more left _____

What reasons are usually given for leaving?

G. BUDGET

1) What is your Ministry approved budget for 1983/84? \$ _____

2) Do you receive funds from any source other than the Ministry of Community and Social Services?

Yes _____

No _____

If yes, from what source? _____

How much? _____

H. PROGRAM EVALUATION

Program evaluation is a process to determine how well a program is achieving its objectives, that is how effective it is, and also to determine how efficiently it is using its resources to accomplish its objectives.

1) What indicators of overall program effectiveness does your agency use?

2) Which do you find most useful in providing the agency with guidance in regard to overall program effectiveness?

3) What indicators does your agency use to measure the efficiency of your providing your service?

I. REPORTING REQUIREMENTS

- 1) Which of the following types of documentation does your program collect on each case? Please indicate the % of files where, if you did a file audit, you would expect to find the documentation present and up-to-date. If you do not collect a particular type of data please indicate by N/A.

Data	Percentage of files
Referral form	_____
Medical report	_____
Assessment report	_____
Family history	_____
Individual treatment plan	_____
Mediator training plan	_____
progress notes	_____
termination summary	_____
formal follow-up data	_____
other, please specify	_____
_____	_____

- 2) Do you report information about your program to the Ministry's Program Supervisor?

Yes _____ No _____

If yes, what type of information?
How often?

- 3) Have you received any directions or guidelines from the Ministry's Program Supervisor or other staff of the area office?

Yes _____ No _____

If yes, in what areas?
How often?

J. COMMUNITY RELATIONSHIPS

- 1) What type of co-ordination is there between your program and other agencies in your community. Please indicate specifically the type of other agency with which you are involved and how.

- 2) Do you find that your staff has the role of case manager or advocate for clients?

Yes _____ No _____

If yes, why do you think this role falls to your agency?

K. PROGRAM STRENGTHS AND CONCERNS

- 1) What do you view as the major strengths of your program?

- 2) What are the key ingredients which contributed to the development of these strengths?

- 3) What are your major areas of concern about your program?
- 4) What ingredients do you believe are responsible for these concerns?
- 5) If someone just developing a new communications program came to you for advice, what would you urge them to do and not to do?
- a) I would urge the person to
- b) I would warn the person about
- 6) What future developments would you like to see in the communication programs across the province. In other words what do you feel would improve the system? Please indicate on a separate sheet of paper.

THANK YOU VERY MUCH FOR YOUR ASSISTANCE

Please complete the questionnaire by NOVEMBER 21, 1983 and return it to:

CAROLYN SHERK
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Executive Summary

This survey of 14 community based communication programs for persons with developmental handicaps identified considerable variety among the relatively few programs in the province. This summary reports on the general findings regarding the variety as well as the similarities among the programs.

Variety Among Programs

Organizational auspices, clientele served, program mandates, approaches to service delivery, role and work environment of speech pathologists, sophistication of equipment, and reporting requirements differ significantly. Because communication programs do not conform to one general model, it is important in understanding the programs to consider these differences:

° Organizational

Sponsorship of the programs can be considered under 4 groups: Associations for the Mentally Retarded, Hospitals, Independent Boards and non-residential Facilities (Surrey Place Centre and Algoma District Mental Retardation Services). The communication programs operated by residential facilities for the developmentally handicapped are not included in this survey.

° Clientele

Clients are usually grouped into three ages: preschoolers, school aged and adult. Some programs limit their services to children, some to preschool children, one serves only adults, and others attempt to serve all ages.

° Mandate

Although most of the programs are similar in their mandates, 3 of the 14 could be regarded as specialized in their focus on research, development and consultation services.

* Role and Working Environment of Speech Pathologists

Speech pathologists in some programs are the front line workers serving the mediator and/or client. In other programs, teachers, assistants or aides work directly with the mediator and the speech pathologist serves as a consultant.

In some programs the speech pathologist is in a sole charge position and responsible for program, management reporting and clerical functions. In some situations, no other professional support staff is employed by the agency. In other agency settings the speech pathologist works as a member of a team with other speech pathologists and usually with other professionals. In the team environment, the manager of the unit is not necessarily a speech pathologist.

* Sophistication of Equipment and Access to Supplies

Two programs use video equipment as part of the learning process for mediators, one has a computer for record keeping and others have easy access to research and library facilities. In other programs supplies and resource support are quite limited. For example, in one program two speech pathologists must share the same assessment kit.

* Reporting Requirements

Many programs have ongoing liaison with Ministry staff and report statistical and program development information quarterly. Speech pathologists in others programs did not know the Ministry's program supervisor and their relationship with the Ministry was limited to the completion of annual budget forms. Internal reporting systems ranged from very detailed to very limited.

Similarity Among Programs

A common goal, a sense of professionalism, concern about limited resources and the need for linkages are themes that recurred throughout this review of the communication programs.

° Common Goal

All programs shared the common goal of improving the communication skills of their developmentally handicapped clients.

° Professionalism

Most of the staff employed by the programs are professionals, trained in speech pathology. The speech pathologists and their managers regarded the professional skills as very important in the delivery of services. There is great interest in improving the expertise of the profession in meeting the needs of this clientele and of others in the general population.

° Limited Resources

The lengthy waiting lists because of the limited resources, both financial and human, are general concerns.

° Need for Linkages

The need to establish linkages among the communication programs in the province was given high priority by most respondents.

The following sections of this report describe these and other findings in greater detail.